

**A STRONG PUBLICLY-FUNDED HEALTH SYSTEM:
KEEPING CANADIANS HEALTHY AND
SECURING OUR PLACE IN A COMPETITIVE WORLD**

**Brief Submitted to the
House of Commons
Standing Committee on Finance**



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EXECUTIVE SUMMARY

The Canadian Healthcare Association (CHA) wishes to thank members of the House of Commons Standing Committee on Finance for the opportunity to contribute to deliberations on the next federal budget. Noting the Committee's focus on healthy citizens, appropriate skill sets, competitive businesses and infrastructure in place, our Pre-Budget Brief shows how a strong, publicly-funded health system will continue to enhance Canadian competitiveness and economic growth, while affirming the core Canadian value of access to health services based on health need rather than the ability to pay.

CHA is the federation of provincial and territorial hospital and health organizations across Canada. Through its members, CHA represents a broad continuum of services provided by regional health authorities, hospitals, facilities and agencies that are governed by Board members and trustees who act in the public interest. CHA is a leader in developing, and advocating for, health policy solutions that meet the needs of Canadians and is committed to a publicly funded health system that provides access to a continuum of comparable health services throughout Canada. CHA was founded in 1931 and this year is celebrating its 75th Anniversary.

Although the September 2004 *Ten-Year Plan to Strengthen Health Care* makes a significant contribution to enhancing Canada's publicly-funded health system, health care is still being identified by Canadians as the most important issue facing Canada. A recent poll by the Strategic Counsel taken in mid July showed that 20% of Canadians identified health care as their number one issue of concern as compared to 15% in June 2005. At 20% this was substantially ahead of the economy, tax cuts and other issues.

Our brief discusses the importance of education/training as a component of health and health human resources, as well as technology, research, and innovation. Our brief also includes, as part of our arguments, the most recent Organization for Economic Co-operation and Development (OECD data released June 2006). Using comparator countries, we examine items such as, public expenditures, private expenditures (including private insurance), the cost of pharmaceuticals and changes in health spending. The most important message arising from the OECD data is that as a percentage of Gross Domestic Product (GDP) and on a per capita basis, Canada's publicly-funded health system is less expensive than that of other countries to which it is often compared. Statements that Canada's health spending is high are usually based on total expenditures (public and private combined); the reality is that Canada's private expenditures are higher than those of most of the comparator OECD countries, while our public spending is less.

OECD data also indicates that between 1990 and 2004, the change in share of Canadian public spending on health was -4.7% (OECD 2006). The real reductions in health spending on the public side during the 1990s had a major impact on the public/private spending ratio in Canada, with private spending still continuing to increase at a faster pace than public spending. There remains, however, a misconception that the cost of health services is out of control and not sustainable for the future, a belief that is not grounded in reality. The numbers show that Canada's health costs are not out of control, especially as compared with leading OECD countries. The reality is that health as an industry is a contributor to the Canadian economy and as a public service has a positive impact on Canada's economic competitiveness.

Our publicly-funded health system is respected internationally for ensuring healthy workers, and affording businesses based in Canada a distinct competitive advantage. The health sector is also a potential source of wealth creation, exports, and 21st century jobs for Canadians. Our single-payer system provides economies of scale that could drive the development of a domestic export industry by building upon our first class health professional training programs, researchers, delivery systems and information technology development. Rather than viewing investments in health innovation and reform as a burden, we should approach them as investments in product development and recognize the health sector as a potential creator of jobs and exports. As a creator of jobs, the health sector impacts positively on the determinants of health as well as the health status of Canadians.

It is often forgotten that the percentage of GDP that is expended on health services - public and private spending combined - has remained between 9 and 10% for over 15 years. There appears to be a disconnect between the reality of health spending, which has changed little as a percentage of GDP on the one hand, and concern over

health costs being out of control on the other. Every country in the developed world is struggling with health costs and searching for solutions to health system challenges – and there are numerous approaches that work, but no single solution. Different countries have different approaches based on their own history and realities and we can learn from them. As well, they can learn from progress being made in Canada. For some the solution is more privatization of funding, based on the premise that shifting health costs to individuals or to their employers makes them less onerous. However, cost shifting is not cost savings. There are solutions and there are points of light, and this brief will try to point to them, but there is no magic.

CHA and its members are strong defenders of Canada's publicly-funded health system. We regard private sector involvement in the funding and delivery of health services as neither inherently evil nor a panacea for the challenges facing our health system. CHA's position concerning the appropriate public-private mix in the funding and/or delivery of healthcare is linked to the principle of access to health services based on health need, not ability to pay. This is a core Canadian value and it cannot be jeopardized. CHA is on record as supporting an evidence-based approach as to when, where, and how private funding and/or delivery can occur.

CHA is committed to working with governments to meet the health needs of Canadians. For this reason, CHA has over the years presented a pre-budget brief outlining our concerns and providing suggested changes/suggesting amendments to improve the health of Canadians and the economic health of the country.

Summary of Recommendations:

1. CHA recommends that any wait times guarantee that the government proposes include special travel funds to operationalize it. It should not be an invitation to legal suits, but should act as a safety valve. As well, the wait times issue needs to be addressed in the broader context of a complex health system with multiple issues to be resolved. The issue is one of quantity, quality, and appropriateness and not quantity alone.
2. CHA recommends as a start a \$1 -billion additional investment over 3 years to support a home care program with ongoing /chronic care services linked to pan-Canadian objectives for home and community care while respecting provincial/territorial jurisdiction regarding the delivery of care. CHA also signals the importance of addressing facility-based long term care on a pan-Canadian basis which remains another area of unfinished business and will, in the future, require additional investments to assure access and quality.
3. To enhance the efficiency and effectiveness of our health system, CHA recommends additional investments of \$6.2 -billion over 5 years to Canada Health Infoway in order to accelerate the development and implementation of a comprehensive interoperable electronic health record with a sufficiently broad scope.
4. CHA recommends that a pan-Canadian health human resource framework or strategy be developed collaboratively with representatives from federal, provincial and territorial governments, and employer and employee stakeholders. Without appropriate health human resources the system cannot be sustained nor needs met regardless of funding invested in infrastructure and technologies.
5. CHA advocates for an appropriate base for the Canada Social Transfer (CST) and an escalator for the CST comparable to that in the Canada Health Transfer.
6. CHA has advocated for enhanced resources targeted to wellness initiatives and is committed to health promotion programs and healthy lifestyle initiatives, as well as investments in the determinants of health. Appropriate chronic disease management programs are an essential part of this work.
7. CHA recommends that federal, provincial, and territorial governments should cooperate to set policies for regulating the price of generic and off-patent (brand name) drugs in parallel with policies for patented pharmaceuticals.
8. CHA notes the importance of encouraging appropriate drug utilization. CHA recommends that in order to obtain the greatest value from funds directed toward drug plans, provincial formularies must relate the coverage of specific drugs to their therapeutic effectiveness. Furthermore, federal, provincial, and territorial governments should ensure the development of guidelines in association with listing recommendations to encourage the appropriate and cost-effective use of all pharmaceuticals.
9. CHA recommends an investment in health research of at least 1% of total health spending.
10. Given the positive impact of Canada's publicly-funded health system on Canada's economic competitiveness and productivity, CHA recommends that any discussion on the appropriate public/private mix in the funding and delivery of health services needs to be based on a rigorous assessment of the evidence. CHA's analysis of the evidence demonstrates the efficiency and effectiveness of Canada's health system and points to the negative consequences for the health system and the Canadian economy of quick fixes or magic solutions, often based on an increased role for private insurance.
11. CHA supports the principle that the federal role in health is to ensure a broad range of comparable health services for Canadians through appropriate funding, while asserting the Canada Health Act and any other legislative and policy frameworks in place, so that pan-Canadian objectives can be achieved. To ensure that F/P/T joint objectives are met, comparable reporting to Canadians on health system performance is essential.

INTRODUCTION

The Canadian Healthcare Association (CHA) is the federation of provincial and territorial hospital and health organizations across Canada. Through its members, CHA represents a broad continuum of services provided by regional health authorities, hospitals, facilities and agencies that are governed by Board members and trustees who act in the public interest. CHA is a leader in developing, and advocating for, health policy solutions that meet the needs of Canadians and is committed to a publicly funded health system that provides access to a continuum of comparable health services throughout Canada. CHA was founded in 1931 and this year is celebrating its 75th Anniversary. To mark this special occasion, CHA is publishing a history of the organization which will reflect the history and evolution of health care in Canada.

THE EVOLUTION OF HEALTH SYSTEM FUNDING

Although the September 2004 *Ten-Year Plan to Strengthen Health Care* (hereafter referred to as the “Ten-Year Plan”) makes a significant contribution to enhancing Canada's publicly-funded health system, health care is still being identified by Canadians as the most important issue facing Canada. A recent poll by the Strategic Counsel taken in mid July showed that 20% of Canadians identified health care as their number one issue of concern as compared to 15% in June 2005. At 20% this was substantially ahead of the economy, tax cuts and other issues.

Though the federal contribution has increased substantially due to the 2004 Ten-Year Plan, it is fitting to review the health funding cutbacks in the 1990s since the effects of these funding restraints are still reverberating through the health system.

From 1993-96, in response to deficits, most governments in Canada imposed serious restraint on public sector health expenditures. As a result, total health expenditures (public and private combined) shrank in real terms despite considerable increases in private sector expenditures.¹ At the federal level, the introduction of the Canada Health and Social Transfer (CHST) in 1996 saw reductions of federal transfers for health, post secondary education and social services of \$2.5 -billion in 1996-97 and \$4.5 -billion in 1997-98.²

Though the federal government enacted ameliorative measures from 1997-2003 to address the earlier funding reductions, OECD data indicates that between 1990 and 2004, the change in share of Canadian public spending on health was -4.7% (OECD Health Data 2006 –Appendix A). Thus the real reductions in health spending on the public side during the 1990s had a major impact on the public/private spending ratio in Canada, with private spending still continuing to increase at a faster pace than public spending.

The Ten-Year Plan added substantial federal dollars to the Canada Health Transfer (the successor to the CHST for health): this includes a total of \$41-billion over 10-years, including an increase to the base of the Canada Health Transfer with a 6-% annual escalator, a fund for medical and diagnostic equipment, and a special wait times trust fund of \$5.5-billion over 10-years. These funds answered CHA's call for predictable and long-term funding with an escalator, which is why CHA supported the 2004 Agreement while noting that there was some unfinished business which would have to be addressed in the future. There remains, however, a misconception that the cost of health services in Canada is out of control and not sustainable for the future, a belief that is not grounded in reality. The numbers show that Canada's health costs are not out of control, especially as compared with leading OECD countries. The reality is that health as an industry is a contributor to the Canadian economy and as a public service has a positive impact on Canada's economic competitiveness.

It is often forgotten that the percentage of GDP that is expended on health services — public and private spending combined — has remained between 9 and 10% for over 15 years. There appears to be a disconnect between the reality of health spending, which has changed little as a percentage of GDP on the one hand, and concern over health costs being out of control on the other. Every country in the developed world is struggling with health costs and searching for solutions to health system challenges – and there are numerous approaches that work, but no single magic solution. Different countries have different approaches based on their own history and realities and we can learn from them. As well, there is much to be learned from progress being made within Canada. For some, the solution is more privatization of funding, based on the premise that shifting health costs to individuals or to their employers makes them less onerous. However, cost shifting is not cost savings. There are solutions and there are points of light, and this brief will try to highlight them, but there is no magic.

CONTRIBUTION OF THE HEALTH SYSTEM TO THE CANADIAN ECONOMY

According to Statistics Canada, the monthly gross domestic product for health care and social assistance in May 2006 was \$63 -billion, a 3% increase over May 2005. This figure represented 5.77% of the total GDP for all industries for the month of May 2006. It captures health care as a service industry, but health has a large professional, scientific and technical component as well. If one includes pharmaceutical and medicine manufacturing as well as medical equipment and supplies manufacturing, the amount contributed to the GDP in 2005 would increase by an additional \$5.6 -billion (or a total of 6.3% of the GDP). Thus, the health sector is a significant component of the Canadian economy.

CANADA'S HEALTH SYSTEM AND ITS IMPACT ON CANADA'S COMPETITIVENESS

It is an important fact that Canada's publicly-funded health system provides a significant competitive advantage to Canadian business due to reduced health benefit costs for Canadian employers. For the auto industry, a sector that generates billions of dollars for the Canadian economy, this advantage amounts to about \$4.00 per hour per worker. General Motors' costs for providing health benefits for its 1.1 million American employees are approaching \$6 -billion. This situation is not exclusive to General Motors, which the company's Chairman and CEO characterizes as a "crisis" that undermines the competitiveness of U.S. companies. Given the high Canadian dollar, any move to increase health spending by Canadian businesses through transferring more health costs to employers would reduce our competitive advantage.

The recent announcement by General Motors that the new Camaro will be produced in Oshawa illustrates the competitive advantage provided by Canada's health system. "The competition is huge", said Chris Piper, a professor at the Richard Ivey School of Business. "Every state governor, every city that's got a plant, the mayor of that city, they were all licking their chops for this one..... they've got a health care situation in Canada that saves the employer thousands of dollars a year in health insurance..." Granted, health care was not the only reason for this investment decision, but it was a significant factor. This is one of a series of auto industry decisions taken because of health costs in Canada.

THE EFFECTIVENESS OF CANADA'S HEALTH SYSTEM: THE TRUTH BEHIND THE NUMBERS

Last year's Supreme Court ruling on private health insurance stimulated increased debate on the effectiveness of Canada's health system. Some contend that countries with public and private funding and delivery options for acute care services outperform Canada's single payer system. CHA analyzed the most recent data from the Organization for Economic Co-operation and Development (OECD) and the results of this analysis refute this claim. As a percentage of Gross Domestic Product (GDP) and on a per capita basis, Canada's publicly-funded health system is less expensive than that of other countries to which it is often compared (Appendices A-D). CHA reviewed the most recent OECD data (2004) for Canada, the United States, the United Kingdom, Sweden, France and Germany.

- **Total Health Expenditures:** In terms of both public and private spending for health, as a percentage of GDP, Canada spent 9.9% in 2004. While this is above the OECD average of 8.6%, so are Sweden (9.2%), France (10.1%), Germany (11%) and the U.S. (15%). At 7.7%, the U.K is below this average but is in the process of substantial reinvestment.
- **Proportion of Public Spending:** The OECD average for public spending on health is 71.6% of total spending. Canada at 69.8% (down 0.3% from the previous year) and the U.S. at 44.7% are below this. In contrast, France at 78.4%, Germany at 78.2%, the U.K. at 85.5% and Sweden at 84.9% are above the OECD and Canadian average in terms of the proportion of public spending on health.
- **Public Spending as a Percentage of GDP:** While at 6.9% Canada is still above the OECD average of 6.3% public spending as a percentage of GDP, France (8.23%), Sweden (7.73%) and Germany (8.52%) are all above the OECD average and these are countries to which Canada is often compared.

- **Public Per Capita Spending:** Regarding public health expenditures per capita, the OECD average is \$1847 while Canada's public spending is \$2209. Of the above comparator countries, only the U.K. (\$2177) is below Canada's level. It should again be noted that the UK is now making substantial investments in their health system. Sweden (\$2398), France (\$2477), Germany (\$2350) and the U.S. (\$2728) are all above the OECD average and the Canadian figures in terms of per capita government spending.

These numbers show that Canada is not overspending in relation to the comparator countries.

In the most recent Canadian Institute for Health Information (CIHI) publication “*Health Care in Canada, 2006*” the chapter entitled “What We Spend” provides striking information. It notes that Canada is somewhere in the middle of the pack on health expenditures of countries that most closely follow the OECD system of health accounts. CIHI also noted that in the last three decades inflation-adjusted private sector health spending rose more quickly than public sector spending — 4.4% versus 3.5% on average per year. Over the last five years, growth rates have been faster, averaging 6% in the private sector and 4.5% in the public sector. Shifting more costs to the private sector will cause health costs to rise even more rapidly. The CIHI report also makes it clear that the fastest area of health expenditure growth is the pharmaceutical sector. The evidence shows that shifting more of the funding burden to the private sector will merely increase total health costs, as will be noted in greater detail toward the end of this document.

WHERE DO WE GO FROM HERE

Although the Ten-Year Plan makes a significant contribution to enhancing Canada's publicly-funded health system, there is still unfinished business and unmet needs in a number of areas; wait times, home/community /long-term care, an electronic health record, health human resources, access to pharmaceuticals, and improving the health and wellness of Canadians. So while it is important to acknowledge that progress has occurred across the country in various ways, CHA believes that improvements still need to be made.

1. WAIT TIMES

At present, the public, governments and health providers are focused on wait times, particularly wait times for diagnostics and certain medical and surgical interventions, which were identified as the priorities in the 2004 Accord. There has been progress over the last several years regarding access to diagnostic services. According to CIHI data, between 1990 and 2005, the numbers of MRIs and CTs grew by 826% and 82% respectively. Much of this growth can be attributed to the federal special funds allocated for diagnostic equipment in the early 2000's.

With respect to wait times, as was noted earlier, there is a special wait times trust fund of \$4.5-billion over six years with an extra \$1-billion for the last four years. First Ministers committed to achieving meaningful wait time reductions in cancer, heart, diagnostic imaging, joint replacement and sight restoration by March 31st, 2007. While the 2004 agreement identified these initial areas of focus, CHA's belief is that the 'hot spots' are a beginning and not an end. Also, CHA sees the wait times issue in the broader context of a complex health system with multiple issues to be addressed. A focus on quantity — the number of procedures and timely access to them — is important, but so too are quality and appropriateness of care.

CHA has stressed the importance of addressing the variety of issues related to wait times such as research in benchmarks or targets leading to evidence based goals, the appropriateness of surgical interventions, best practices related to managing demand for services, managing the waiting process through health maintenance and support programs and case navigators, effective health human resource strategies, an integrated approach to waiting lists, efficient use of operating room time, appropriate information and management systems, including an electronic health record, and the application of queuing theory.

The establishment of processes that support and guide patients is particularly important. And above all, it is essential to ensure public reporting and transparency regarding wait times. Citizens have the right to review the timelines regarding their access to care and to be assured their needs are being addressed in a timely way. A wait time guarantee was promised by the federal government which undertook to discuss with the provinces and territories the concept of a guarantee. This guarantee would ensure that people waiting for health services would have their travel costs to another region or province or even out of country paid for, if they did not receive access

to care within an evidence-based targeted timeline. Given the complexity of the wait times issue, this guarantee would need to be carefully defined. It would be difficult to justify the diversion of money needed to provide timely care in our own country to travel costs and more expensive services in the United States. If introduced, the definition of a guarantee should minimize the potential of legal suits, while acting as a safety valve or last resort when timely access has not been obtained. CHA does not support the wait times guarantee, but notes the importance of safety valve mechanisms, which already exist in most Canadian jurisdictions. And while the 2004 Accord provides a wait times fund, to be used to address the five “hot spots” and to achieve targets and benchmarks related to them, there is no mention in the Accord of a wait times guarantee.

A wait times guarantee would require special travel funds to operationalize it. As well, the wait times issue needs to be addressed in the broader context of a complex health system with multiple issues to be resolved. The issue is one of quantity, quality, and appropriateness and not quantity alone.

2. HOME, COMMUNITY AND LONG-TERM CARE:

CHA has long advocated for a home and community care program that provides both acute care replacement services and ongoing continuing/chronic care. There is a commitment in the Ten-Year Plan to provide post-acute home care on a short-term basis as well as short term community mental health and end-of-life care; however there is no commitment to continuing/chronic care in the community. Hollander, in a study of the cost-effectiveness of chronic home care found that over time, and for all levels of care needs, home care, on average, was significantly less costly than care in a long-term care facility.³ However, a substantial component of home care is provided by informal (family, friends) caregivers with an estimated 2.1 million unpaid informal caregivers providing \$5 -billion a year in savings for the health system. Home care does not come without costs to individual Canadians and the Canadian economy.

The 2002 General Social Survey conducted by Statistics Canada provided compelling information on the “hidden” costs of home care. The survey identified the following information:

- Most caregivers work outside of the home.
- More than 1/3 of caregivers incur extra expenses.
- 27% of women and 14% of men had to change work patterns (i.e. working split shifts, leaving early and making up time).
- 20% of women and 13% of men reported reducing work hours.
- 11% of women and 9% of men reported lost income.
- 3% of women and 3% of men reported turning down a job or promotion.
- 2% of caregivers had to quit a paid job.

The labour market effects on family caregivers were most revealing. The majority of the informal caregivers were 45 to 54 years old and in their most productive work years. Unpaid caregivers also incur out-of-pocket expenses with an estimated average annual expense of \$1569, totaling \$2.287 -billion⁴. In addition to the loss of income through foregone employment, there is also the loss or reduction of employer-sponsored benefits, Canada Pension Plan credits, training opportunities, experience in one’s field and promotions^{5,6}. Tensions between family caregiving and work responsibilities also resulted in job dissatisfaction, absenteeism, work interruptions and extended absences as well as possible career costs through foregone promotions and restricted opportunities⁷. Thus from an economic point of view, it is essential that a pan-Canadian approach to home care services that includes continuing/chronic care as well as acute care is essential.

CHA has always urged that the *Canada Health Act* medically necessary services must continue to be publicly-funded (single-tier) along with acute care replacement home care services, but has also recognized that there is room for co-payments for some services (e.g. home support services for some clients, reasonable accommodation payments for facility-based long term care, and co-payments for pharmaceuticals, provided that this does not reduce access). Therefore, CHA is not recommending that all costs associated with a continuing/chronic care, home care program be covered. There should be a social analysis and a fair process for establishing co-payment levels.

While there are a number of tax and EI changes that can support the chronic/continuing care needs of Canadians, these are not a replacement for a comprehensive package of continuing care services including programs such as respite to support caregivers.

CHA recommends as an initial measure a \$1 -billion additional investment over three (3) years to support a home care program with ongoing /chronic care services linked to pan-Canadian objectives for home and community care, while respecting provincial/territorial jurisdiction regarding the delivery of care. CHA also signals the importance of addressing facility-based long term care on a pan-Canadian basis which remains another area of unfinished business and will, in the future, require additional investments to assure access and quality.

3. ELECTRONIC HEALTH RECORD

An electronic health record (EHR) is pivotal to moving forward on many of the health renewal priorities established by First Ministers. Improved access to care, high quality services and the efficiency and effectiveness of the health system are all linked to an accelerated implementation of an inter-operable, comprehensive, pan-Canadian electronic health record.

Three recent reports have emphasized the importance of accelerating the introduction of electronic health records.

1. Matthew Morgan⁸ noted the need for the EHR as a fundamental tool for patient safety. He noted that the health system will deteriorate in terms of safety and quality if its foundation is paper-based. Using data from an American study and extrapolated to the Canadian situation, he estimated that if 75% of Canadian family physicians adopted technology in their ambulatory practices, once fully implemented this would save \$236 million annually. The paper also indicates that a fully implemented in-patient computerized order entry could save Canadian hospitals \$1.2 -billion annually.
1. The recently released report from the conference held in June 2006 and sponsored by Canada Health Infoway (CHI) and the Health Council of Canada on the electronic health record provides data on the return on investment of a fully developed electronic record:
 - The Booz Allen Hamilton⁹ study in Canada estimated savings of \$6 -billion annually with a fully developed EHR, which would cost about \$1 -billion a year for 10 years to implement.
 - The Ontario Telehealth Network saved \$5.2 million in travel grants alone in 2005-06, with 20 million kilometres of travel avoided.
 - In Edmonton, the use of the telephone and fax for exchanging laboratory and other information plummeted as use of the computerized portals increased.
3. Federal Wait Times Advisor Dr. Brian Postl, in his report on wait times, noted the benefits of an EHR for the health system. These include: increased access to integrated patient information; reduced duplicate tests and prescriptions; reduced physician prescription call backs; reduced patient and provider travel costs; improved vaccine management; and improved information management resulting in reduced costs.

The original goal and mandate of CHI falls short of what is needed. The objective must be 100% coverage of the Canadian population, comprehensiveness in terms of the settings included in the EHR (e.g. hospitals, long term care facilities, home care, physicians' offices, health clinics), and a broader scope as to what will be included in the record. As well, the timetable for implementation needs to be stepped up. This will take substantial investment, but failure to proceed in a timely way will cost more.

To enhance the efficiency and effectiveness of our health system, CHA recommends additional investments of at least \$6.2 -billion over 5 years to CHI in order to accelerate the development and implementation of a comprehensive inter-operable electronic health record with a sufficiently broad scope.

4. HEALTH HUMAN RESOURCES

The shortage of health human resources (HHR) remains a serious problem. In the next five years, about 20% of physicians and 33% of nurses will be ready to retire. Yet there are not enough young professionals to replace those who are leaving. This shortage extends beyond physicians and nurses to all other health providers. In September

2004, the First Ministers agreed that their governments will increase the supply of health professionals based on gap assessments and make their action plans public, including targets for training, recruitment and retention of professionals by December 31, 2006. CHA notes that recruitment; retention and other key issues are being recognized and potentially addressed. However, these initiatives need to be coordinated at a pan-Canadian level.

Tackling the issue of HHR is important not only from the viewpoint of wait times and human resource shortages, but also from the perspective of the Canadian economy. The majority of health personnel possess a post secondary education. Statistics Canada has identified average earning of the population by highest level of schooling (2001 Census). An individual with less than high school graduation could expect to earn an average of \$21,230 contrasting with individuals with a college certificate (\$32736) or a university degree (\$48648) who earned considerably more. In addition individuals with a post secondary certificate or Bachelor's degree were more likely to be employed during their whole working lifetime. Simply put, the health sector is a significant source of high paying jobs, and an important contributor to the economy and tax revenues.

The Budget of May 2006 committed to moving forward in the creation of an agency to ensure foreign-trained immigrants meet Canadian standards. Appropriate employment of immigrants who are well-educated and highly skilled will improve productivity and help ease the human resource shortage. Recognizing that provinces have control over the regulation of health providers, employers would benefit from coordination at the pan-Canadian level to identify need for foreign-trained providers. However, CHA does not support the recruitment of health professionals from lesser developed countries who also have an HHR shortage and recommends that the federal government work with its G-8 partners to meet internal needs for health providers and reduce the pressure to recruit from under-resourced countries.

CHA encourages a move toward credentials for regulated providers that are standard across the provinces and territories. CHA also supports training that: fosters team approaches; facilitates communication and community development that engages the public, all health providers and health organizations; and works to ensure client acceptance, satisfaction and confidence.

CHA recognizes the undisputed necessity of achieving a stable health system work force with the right number, mix and distribution of health providers, in order to provide reasonable access to high quality care for all Canadians.

CHA recommends that a pan-Canadian health human resource framework or strategy be developed collaboratively with representatives from federal, provincial and territorial governments, and employer and employee stakeholders. Without appropriate health human resources the system cannot be sustained nor needs met regardless of funding invested in infrastructure and technologies.

5. INVESTING IN HEALTHY CANADIANS

5.1 Social determinants of health

The OECD average for life expectancy at birth is 77.8 years. The U.S. (77.2 years) is below this while Germany (78.4 years), the U.K. (78.5 years), France (79.4 years) and Canada (79.7 years) are all above the average, and Sweden (80.2 years) has the highest life expectancy at birth of these six countries.

Life expectancy and health status depend on more than health system expenditures. Education, income levels, housing, social services, the environment and healthy lifestyles are also important determinants of health, which is why there is such concern about health spending crowding out education and social spending at the provincial and territorial level. The greatest share of health problems is attributable to the social conditions in which people live and work (social determinants of health). Good health care is vital to the well being of society but so are the other determinants of health. Illness and poor health have a negative impact on tax revenue, corporate profits and wage-based productivity which in turn causes less money to be available to fund government initiatives such as health, education, housing etc. Labour market/human resource and educational policies, that is, policies that address major structural determinants of health, provide a substantial return on investment in terms of establishing and maintaining a healthy citizenry.

Better health allows more people to participate in the economy, reducing the costs of lost productivity.

Budget 2006's one-time investment of \$1-billion (paid into a third-party trust) for educational infrastructure, and educational /employment tax credits as well as the one-time \$800 -million payment to address short term pressures with regard to affordable housing are a start to addressing some of these issues.

Since these factors play an important role in ensuring a healthy society, CHA advocates for an appropriate base for the Canada Social Transfer (CST) and an escalator for the CST comparable to that in the Canada Health Transfer.

5.2 Primary Health Reform

With respect to primary health care, in order to meet the 2003 health accord objective of 50% of Canadians having 24-hour, seven day a week access to multidisciplinary teams by 2011, First Ministers agreed to establish a 'best practices network' to share information and find solutions to barriers to primary health care reform.

CHA has noted the importance of meeting the targets originally set out in the 2003 Health Accord regarding Primary Health Care Reform. Primary health care teams are being established across this country, but not quickly enough.

5.3 Public Health

One of the solutions to reducing health spending — or at least maintaining sustainable increases — is greater investment in public health, particularly in areas such as healthy life styles (e.g. anti-smoking programs), the prevention of injuries through seat belts and helmets, the prevention and management of chronic diseases (which utilize 70% of acute care services), and seniors' safety programs to prevent falls. Together with spending money on the determinants of health such as education and social services — as noted earlier — we would move a long way to the long-term management of health delivery costs.

It was only in 2004 that CIHI began reporting public health spending as a separate category of health expenditure, that is, spending on the public health system, including the prevention and control of infectious diseases, safe water and food, pandemic preparation and emergency preparedness, population health strategies, healthy living programs, injury prevention programs, prevention and control of chronic diseases, etc. With the establishment of the Public Health Agency of Canada and in the wake of the SARS outbreak, this sector has recently been the focus of enhanced funding and attention. In 1975, public health accounted for 3.7% of total health spending and 4.4% of public-sector health spending. In 2005, \$7.8 -billion was spent on public health, accounting for 5.5% of total health spending and 7.9% of public-sector health spending.

The fact is that governments and health stakeholders need to work on ways to reduce future health costs while providing health services now to those who require them. This isn't an 'either/or' proposition. We need to work to reduce demand in the future while meeting needs today.

CHA calls for enhanced resources targeted to wellness initiatives and is committed to health promotion programs and healthy lifestyle initiatives, as well as investments in the determinants of health. Appropriate chronic disease management programs are an essential part of this work.

6. PHARMACEUTICAL POLICIES

Currently the Patent Medicine Prices Review Board (PMPRB) monitors and regulates the price of patented medicines, but not generic medicines. In general, the price of generic pharmaceuticals is higher in Canada than in many other OECD countries. The PMPRB reported that the price of generic drugs in Canada exceeded the median of foreign prices by 21% to 51% (2003). As of October 2005, federal/provincial/territorial (F/P/T) governments gave PMPRB the responsibility to monitor and report on the price of non-patented drugs.

The cost of prescription medicines has increased from 8% (1990) to 14.6% (2004) of the total expenditures for health (OECD 2006). When we examine OECD statistics for drug expenditures we find that Canada's proportion of private funding is larger than most OECD countries. In 2004, private payments represented 62% of Canada's total drug costs while the average for the OECD countries was 39%. The rising cost of pharmaceuticals, especially compared to increases in health expenditures overall is a cause for concern and points to the need for more information about the value of pharmaceuticals. Private sources tend to play a much greater role in paying for

pharmaceuticals than for hospital or ambulatory care, because drugs are less well-covered under our publicly-financed health system. Employer-based drug coverage is administratively successful, but with the increasing cost of health benefit plans, it is potentially under threat. Employers may be forced to eliminate productive employees with high drug costs or shift more of the costs of health benefit plans to employees.

It is imperative that the health system have solid evidence on the cost-effectiveness of drugs, in order for employers (all sectors), drug plan managers, governments, and health system managers to improve the quality of their decision-making around costs and utilization. Thus the federal government and industry should encourage and support the development of cost-effectiveness research, and health system funders, managers, and health providers (including physicians, nurse practitioners, and pharmacists) should incorporate cost-effectiveness analysis in their decision-making, while optimizing outcomes and sustainability across the system.

CHA recommends that federal, provincial, and territorial governments should cooperate to set policies for regulating the price of generic and off-patent (brand name) drugs in parallel with policies for patented pharmaceuticals.

CHA notes the importance of encouraging appropriate utilization and recommends that in order to obtain the greatest value from funds directed toward drug plans, provincial and territorial formularies must relate the coverage of specific drugs to their therapeutic effectiveness. Furthermore, federal, provincial, and territorial governments should ensure the development of guidelines in association with listing recommendations to encourage the appropriate and cost-effective use of all pharmaceuticals.

7. RESEARCH

The link between research and economic development is well known. So too is the importance of research for the delivery of efficient, high quality, effective health services. The Canadian Institutes of Health Research (CIHR) requires sufficient funding to carry out its various research objectives, including biomedical, clinical, population health and health systems research. In recent years, Canada has moved ahead in health research through the CIHR, the Canada Foundation for Innovation, research chairs, increased support to funding bodies, etc... It would be unfortunate if momentum is lost due to insufficient future increases in funding.

CHA recommends an investment in health research of at least 1% of total health spending.

PRIVATE HEALTH INSURANCE AND ITS IMPACTS

The concern that the publicly-funded health system does not meet the needs of Canadians in a timely way and that it costs too much leads some to look to private health insurance and delivery as a magic solution. In addition, the Supreme Court's ruling on private health insurance increased debate on the effectiveness of Canada's health system. However private insurance options as well as private delivery clinics are not a panacea.

When looking at private funding and private delivery one must consider seriously the impact on Canadian industries that are in global competition. Private health insurance, that is the money paid out by insurance companies on health services, averages around 6% of total health spending across OECD countries. In Canada, private health insurance is 12.7% of overall health spending, up from 8.1% in 1990. The amount of Canadian dollars spent on private insurance has increased substantially from 1990 to 2004. OECD data indicates that the amount spent on private insurance in Canada from 1990 to 2004 has increased from \$5.8 -billion to \$14.8-billion (expressed at 2000 GDP level). A major portion of these funds is provided by employers. Increases in these employee benefits change our competitive edge in the global market.

A 2005 editorial in the New York Times¹⁰ noted that the great advantage of universal, government-provided health insurance is lower costs. Canada's government-run insurance system has much less bureaucracy and much lower administrative costs than the American largely private system. OECD data indicates that the cost of administering the private insurance system in Canada is 2.2% of the total health expenditures whereas administration of the public system accounted for 1.9% of the total health expenditures. Put in perspective, it takes considerably more funds to administer 30% of the health dollars (private component) than it does to administer 70% of the health dollars (public component).

A 2004 OECD policy brief entitled “Private Insurance in OECD Countries” made several important points:

- (1) Countries with significant private health insurance options tend to be those with the highest health spending levels;
- (2) Private health insurance has not significantly reduced public financing burdens;
- (3) Access to private health insurance is often inequitable, largely because private health insurance is typically purchased by high income groups;
- (4) Higher-risk patients find it difficult to obtain coverage resulting in segregation of the health insurance market by risk level.

Our publicly-funded health system is respected internationally for ensuring healthy workers, and affording businesses based in Canada a distinct competitive advantage. The health sector is also a potential source of wealth creation, exports, and 21st century jobs for Canadians. Our single payer system provides economies of scale that could drive the development of a domestic export industry, by building upon our first class health professional training programs, researchers, delivery systems, and information technology development. Rather than considering investments in health innovation and reform a burden, we should approach them as investments in product development and we should recognize the health sector as a potential creator of jobs and exports. As a creator of jobs, the health sector impacts positively on the determinants of health as well as the health status of Canadians.

CHA and our members are strong defenders of Canada's publicly-funded health system. Having said this, we regard private sector involvement in the funding and delivery of health services as neither inherently evil nor a panacea for the challenges facing our health system. CHA's position concerning the appropriate public-private mix in the funding and delivery of healthcare is linked to the principle of access to health services based on health need, not ability to pay. This is a core Canadian value and it cannot be jeopardized. CHA is on record as supporting an evidence-based approach as to when, where and how private funding and/or delivery can occur.

Simple solutions like privatizing more costs have been proposed by some. Others have proposed more contracting out to private surgical clinics. These private clinics may generate cost savings when doing repetitive routine procedures, so there is a need to examine this option provided that quality and accountability are assured. However, we need to understand that the public hospitals will still be left with the expensive complex procedures resulting from patients with high risk factors and co-morbidities. It is easy to provide care at lower costs when you can select your patients. The American Hospital Association (AHA) has expressed concern about cream-skimming private clinics that transfer the burden of unexpected complications and adverse events to full service hospitals.

That is why CHA and our members continue to support a responsive, largely publicly-funded health system, with delivery models that recognize the complexity of the health sector and are based on evidence — a health system that cares about not only quantity, but quality and appropriateness of care. We believe that this kind of system is in the best interest of Canadians, serving to enhance competitiveness and economic growth.

Given the positive impact of Canada's publicly-funded health system on Canada's economic competitiveness and productivity, CHA recommends that any discussion on the appropriate public/private mix in the funding and delivery of health services needs to be based on a rigorous assessment of the evidence. CHA's analysis of the evidence demonstrates the efficiency and effectiveness of Canada's health system and points to the negative consequences for the health system and the Canadian economy of quick fixes or magic solutions, often based on an increased role for private insurance.

ACCOUNTABILITY AND REPORTING TO CITIZENS

All governments have agreed to publicly report on health system performance and to seek advice from experts and health providers on appropriate indicators to measure performance. Governments are reporting on an annual basis, and the Health Council of Canada has issued reports as well.

CHA is pleased with the commitment to develop pan-Canadian indicators and recognizes that public reporting has come a long way. However, there is still more work to be done to produce comparable reports to Canadians on health system performance. CHA believes that the federal government cannot write a blank cheque without being assured of achieving pan-Canadian objectives and agreed-upon performance outcomes, while recognizing that the

delivery of health services is a provincial/territorial responsibility and some flexibility will be needed to address regional realities. The 2004 Accord legislation provides for a federal parliamentary review in 2008 on progress achieved and this will be an opportunity to review whether the objectives set out in the 2004 Ten-Year Plan are being met.

CHA supports the principle that the federal role in health is to ensure a broad range of comparable health services for Canadians through appropriate funding, while asserting the Canada Health Act and any other legislative and policy frameworks in place, so that pan-Canadian objectives can be achieved. To ensure that F/P/T joint objectives are met, comparable reporting to Canadians on health system performance is essential.

FISCAL IMBALANCE ISSUES

The federal government is committed to address the perceived fiscal imbalance that exists between the provinces/territories and Ottawa so as to provide the provinces with the enhanced funds necessary for improving the social programs that they deliver. CHA noted in its 2006 election platform comparison document *“If the fiscal imbalance is to be addressed through the transfer of tax room to the provinces and territories to increase funding for health services in the future, this could hinder rather than help achieve comparable access to health services across Canada.... It is important to note that the value of tax points reflects the relative state of the provincial and territorial economies and varies widely across the country; and thus the ability to fund needed health services could be severely compromised in some regions if tax point transfers were to be used in the future.”* CHA has long supported equal per capita cash transfers in areas where pan-Canadian objectives are important (e.g. Health), and this was the principle underlying the 2004 Health Accord. The equal per capita cash commitment is taking a long time to realize, due to the inclusion of the historical 1977 tax point transfers as part of the equal per capita calculation.

CHA also recognizes the role of an appropriate equalization program to address issues of different fiscal capacities amongst provinces and territories, so that they can deliver comparable social programs with comparable levels of taxation.

While the delivery of health services is a provincial/territorial responsibility, the federal government has traditionally used its constitutional spending power to assert the Canada Health Act and achieve pan-Canadian objectives for health. The CHA has long supported this pan-Canadian approach, while recognizing that the provinces and territories require flexibility in responding to their unique situations.

CONCLUSION: CHA'S SOLUTIONS AND RECOMMENDATIONS

Health care funding has changed substantially in the last three years. However, there is still unfinished business in healthcare and the objectives and deadlines in the Ten-Year Plan still need to be met.

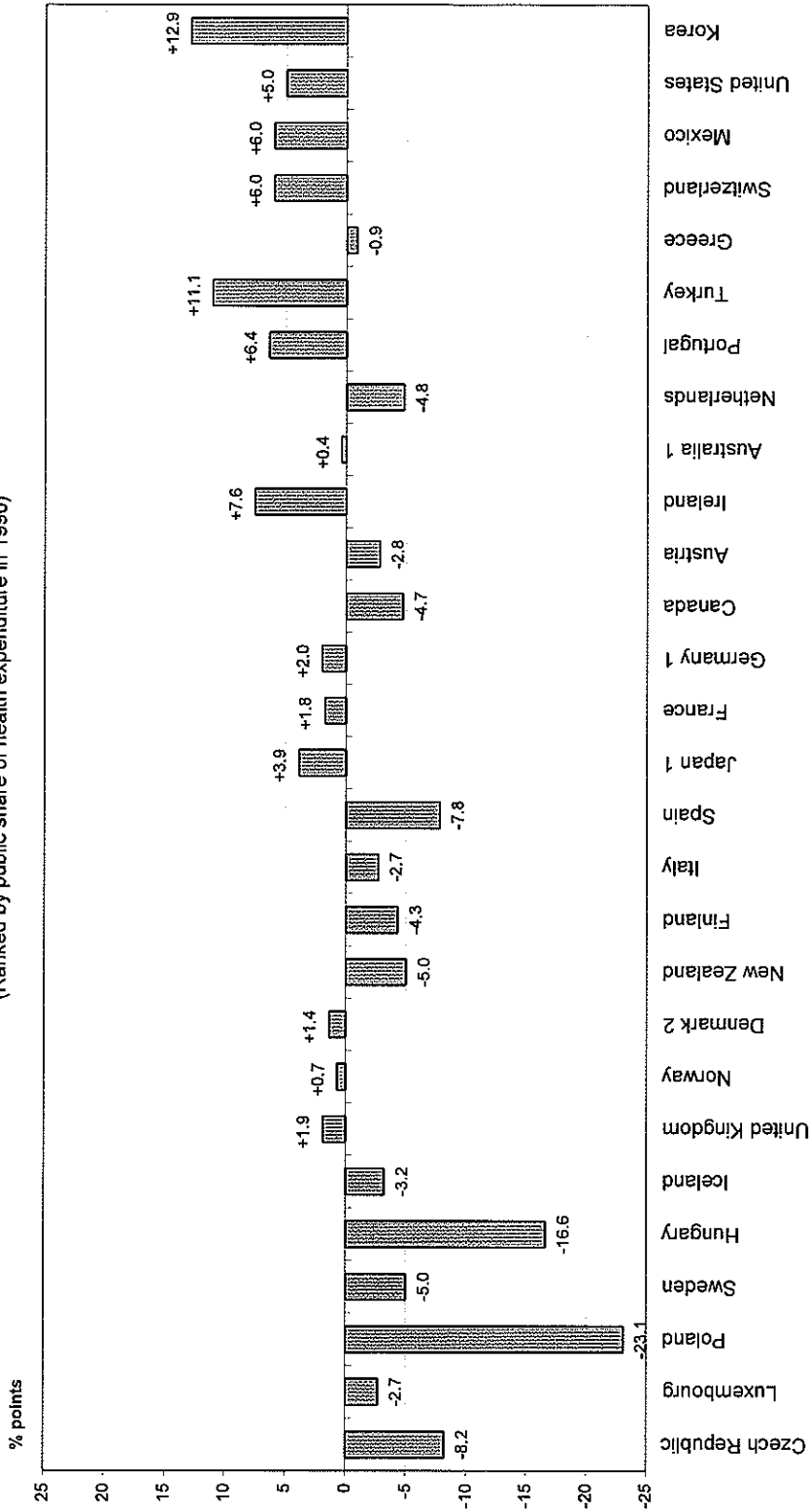
In conclusion, it is useful to recall the words of Commissioner Romanow in his final report: "Medicare has consistently delivered affordable, timely, accessible and high quality care to the overwhelming majority of Canadians on the basis of need, not income. It has contributed to our international competitiveness, to the extraordinary standard of living we enjoy, and to the quality and productivity of our work force."¹³

ENDNOTES

- ¹ CHA Press. **The Private-Public Mix in the Funding and Delivery of Health Services in Canada: Challenges and Opportunities**. CHA Policy Brief, Ottawa, 2001, p. 16, citing data from the Canadian Institute for Health Information from **National Health Expenditure Trends, 1975-2000**.
- ² Minister of Finance the Hon. Paul Martin. **Budget Speech 1995**.
- ³ Hollander, M. (2001) *final Report of the Study on the Comparative Cost Analysis of Home Care and Residential Care Services – Substudy 1*. Victoria BC: Hollander Analytical Services Ltd and the National Evaluation of the Cost-Effectiveness of Home Care
- ⁴ Economic Security for Caregivers: A Policy Development Process to Better Support Unpaid Caregivers – Summary Report from the Unpaid Caregiving Forum convened by The Canadian Association for Community Living and the Canadian Caregiver Coalition
- ⁵ Fast, Janet (1997) *Conceptualizing and Operationalizing the Costs of Informal Elder Care*. Final Technical Report to the National Health Research Development Program, March 17, 1997.
- ⁶ Fast, Janet, Jacque Eales and Norah Keating (2001) *Economic Impact of Health, Income Security and Labour Policies on Informal Caregivers of Frail Seniors*. Final Technical Report to Status of Women Canada, March, 2001.
- ⁷ Gignac, Monique, Kevin Kelloway and Benjamin Gottlieb (1996) The Impact of Caregiving on Employment: A Mediation Model of Work-Family Conflict. *Canadian Journal of Aging* 15(4): 525-42.
- ⁸ Morgan, Matthew (2004) In pursuit of a Safe Canadian Healthcare System. *Healthcare Papers* 5(3)
- ⁹ Booz/Allen/Hamilton – Pan-Canadian Electronic Health Record: Quantitative and Qualitative Benefits, March 2005
- ¹⁰ Paul Krugman. "One Nation, Uninsured", **The New York Times**, June 13, 2005.
- ¹¹ Canadian Health Services Research Foundation. "Myth: A private parallel system would reduce waiting times in the public system", **Mythbusters**, 2001, p. 2.
- ¹² Stephen Lewis. "Private health care will line doctors' pockets — whether they opt out of the public system or not", **Winnipeg Free Press**, August 14, 2005.
- ¹³ Commissioner Roy J. Romanow, Q.C., **Building on Values: The Future of Health Care in Canada — Final Report**, 2002, p. xvi.

Appendix A

Chart 4. Change in share of public spending on health, OECD countries, 1990-2004
 (Ranked by public share of health expenditure in 1990)



1. 2003. 2. Current public expenditure as share of Total current expenditure. Source: OECD Health Data 2006, June 2006.

Appendix B

OECD Health Data (June 2006)

	<i>% of Health Spending Financed by Public Sector</i>			<i>Total Spending as a % of GDP (i.e. public & private expenditures)</i>			<i>Government Spending as a % of GDP (i.e. public sector expenditures only)**</i>		
	2002	2003	2004	2002	2003	2004	2002	2003	2004
Australia	68.1	67.5		9.1	9.2		6.20	6.21	
Canada	69.6	70.1	69.8 e	9.7	9.9	9.9 e	6.75	6.94	6.91
France	78.1	78.3	78.4 e	10.0 b	10.4	10.5 e	7.81	8.14	8.23
Germany	78.6	78.2		10.8	10.9		8.49	8.52	
Sweden	85.1	85.4	84.9 e	9.1	9.3	9.1 e	7.74	7.94	7.73
UK	83.4	85.4	85.5	7.7	7.9	8.3 d	6.42	6.74	7.10
USA	44.8	44.6	44.7	14.7	15.2	15.3	6.59	6.78	6.84
OECD Average	72.7	72.5	71.6	8.6	8.8	8.9	6.20	6.20	6.3

	<i>Total Health Spending Per Capita in US \$ (i.e. public and private expenditures)</i>			<i>Gov't Health Spending Per Capita in US \$ (i.e. public sector expenditures only)**</i>		
	2002	2003	2004	2002	2003	2004
Australia	2700	2876		1839	1941	
Canada	2861	2998	3165 e	1991	2102	2209
France	2886b	3048	3159 e	2254	2387	2477
Germany	2918	3005		2294	2350	
Sweden	2593	2745	2825 e	2207	2344	2398
UK	2228	2347b	2546 d	1858	2004	2177
USA	5324	5711	6102	2385	2547	2728
OECD Average	2275	2427	2582	1652	1749	1847

Appendix C

Total expenditures on Private health insurance, (expressed as a %age of total health expenditures (public and private))

	1990	1995	2000	2002	2003	2004
<i>Australia</i>	11.4	10.7	6.8	7.4		
<i>Canada</i>	8.1	10.3	11.5	12.7	12.7	12.8 e
<i>France</i>	11.0	11.9	12.6	12.3 b	12.2	12.4 e
<i>Germany</i>	7.2	7.6	8.3	8.6	8.8	
<i>Sweden</i>						
<i>United Kingdom</i>	3.3	3.2				
<i>United States</i>	34.0	33.5	35.1	36.0	36.5	36.7
<i>OECD Average</i>	6.5	6.7	6.5	6.1	6.1	6.5

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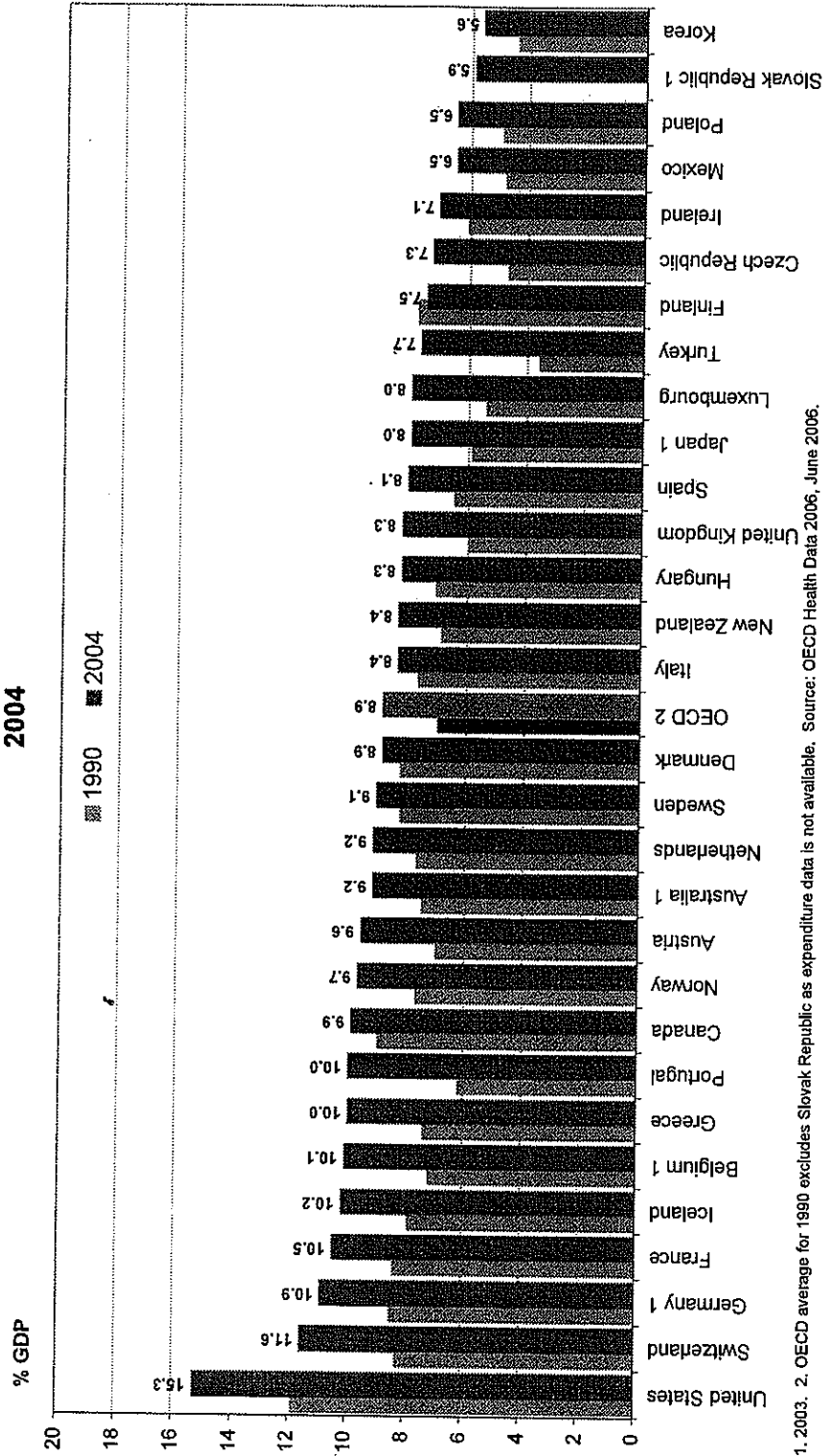
Total expenditures on pharmaceuticals and non durables (expressed as a %age of total health expenditures)

	1980	1985	1990	1995	2000	2002	2003	2004
<i>Australia</i>	8.0	8.1	9.0	11.2	13.5	14.2		
<i>Canada</i>	8.5	9.6	11.5	13.8	15.9	16.7	17.0	17.7 e
<i>France</i>	16.0	16.2	16.9	17.6	20.3	18.7 b	18.8	18.9 e
<i>Germany</i>	13.4	13.8	14.3	12.7	13.6	14.5	14.6	
<i>Sweden</i>	6.5	7.0	8.0	12.3	13.8	13.0	12.6	12.3 e
<i>United Kingdom</i>	12.8	14.1	13.5	15.3				
<i>United States</i>	9.0	8.9	9.1	8.9	11.7	12.3	12.4	12.3

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Appendix D

Chart 1. Change in health expenditure as a share of GDP, OECD countries, 1990 and 2004



1. 2003. 2. OECD average for 1990 excludes Slovak Republic as expenditure data is not available. Source: OECD Health Data 2006, June 2006.